Special Terms and Conditions of Approval

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00116/6

TITLE: *IndependentChoices*: Arkansas Cash and Counseling Demonstration

AWARDEE: Arkansas Department of Human Services

The following are Special Terms and Conditions for the award amendment of the Arkansas Cash and Counseling Demonstration, *IndependentChoices,* under a Medicaid Section 1115 Demonstration. This extension and amendment request, to remove the experimental design so that all demonstration participants receive the cash allowance, was submitted on May 16, 2002. The Special Terms and Conditions are arranged in eight subject areas: General Program Requirements, General Reporting Requirements, Legislation, Assurances, Operational Protocol, General Financial Requirements, Monitoring Budget Neutrality, and a Summary Schedule of Reporting Items.

Letters, documents, reports, or other materials that are submitted for review or approval must be sent to the Centers for Medicare & Medicaid Services (CMS) Central Office Demonstration Project Officer and the State representative in the CMS Regional Office.

I. GENERAL PROGRAM REQUIREMENTS

1. **Extension or Phase-out Plan.** The State will discuss demonstration extension plans with CMS at least 18 months prior to demonstration expiration, and requests for extensions are due to CMS no later than 12 months prior to the expiration of the demonstration. If the State does not request an extension, it must submit a phase-out plan, which includes provisions for cessation of enrollment, to CMS no later than 12 months prior to the expiration of the demonstration. The phase-out plan will be submitted for CMS to review and consider for approval.

2. **Cooperation with Federal Evaluators.** The State will fully cooperate with Federal evaluators and their contractor's efforts to conduct an independent Federally funded evaluation of the demonstration program.

3. **The CMS Right to Suspend or Preclude the Demonstration During Implementation.** The CMS may suspend or preclude State demonstration implementation and/or service provision to demonstration enrollees whenever it determines that the State has materially failed to comply with the Special Terms and Conditions or other terms of the project, and/or if the implementation of the project does not further the goals of the Medicaid program.

4. **The CMS Right to Terminate or Suspend the Demonstration During Operation.** During demonstration operation, CMS may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with any of the terms of the project. The CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights to challenge CMS' finding that the State materially failed to comply. The CMS reserves the right to withhold approval for the demonstration project or withdraw such approval at any time, if it determines that granting or continuing the demonstration project would no longer be in the public interest. If the demonstration project is terminated by action of CMS, CMS will be liable for only normal closeout costs. The State will submit a phase-out plan for CMS to review and consider for approval.

5. **State Right to Terminate or Suspend Demonstration.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for suspension or termination, together with the effective date. If the demonstration project is terminated by the State, CMS will be liable for only normal closeout costs. The State will submit a phase-out plan for CMS to review and consider for approval.

II. GENERAL REPORTING REQUIREMENTS

(Attachment C provides a summary of the frequency of required reporting items.)

6. **Monthly Progress Calls.** Before and up to 3 months after implementation, CMS and the State will hold monthly calls to discuss demonstration progress and the State will respond to questions from CMS regarding any issues.

7. **Quarterly & Annual Progress Reports.** The State will submit quarterly progress reports that are due 60 days after the end of each quarter. The fourth quarterly report of every calendar year will include an overview of the past year as well as the last quarter, and will serve as the annual progress report. The CMS reserves the right to request the annual report in draft. The reports must address, at a minimum:

   - A discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures);
   - Notable accomplishments, including findings from Quality Assurance, beneficiary survey and evaluation activities; and,
   - Problems/issues that were identified and how they were solved.
   - The awardee shall construct a database of all participants in the demonstration, whether the individual was enrolled in the State's home and community based waiver (HCBW) or regular Medicaid personal care services program prior to enrollment in the demonstration. This data base shall at a minimum include identifying information for all participants (name, address, social security number, telephone number), participation start date, the effective date a participant no longer receives cash, the actual participation stop date (i.e., date participant ceases receiving any Medicaid personal care services or HCBW benefits), an indication of whether the participant is assigned to either the treatment or control group, an indication of whether the participant was enrolled in the demonstration as a "new" client or a "current" client for purposes of calculating the new to current client enrollment ratio caps, aggregate monthly enrollment totals for both the treatment and control groups, total cash payments (by quarter) for those individuals within the treatment group, and claim payment amounts (by quarter) for individuals within the control group for those services that would have been used as the basis for establishing cash payments had the participant been selected as a treatment group member. The information in this database will be used to generate an Attachment to each quarterly report providing individual-level and aggregate data for all participants in the demonstration.

8. **Final Report.** At the end of the demonstration, the State will submit a draft final report to CMS for review and comments. The final report with CMS' comments is due no later than 180 days after the termination of the project.

III. LEGISLATION

9. **Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter (of which these Special Terms and Conditions are part), will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the Demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement.

   If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

10. **Changes in Federal Law Affecting Medicaid Expenditures.** The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt State Section 1115 Demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law.

    If the new law cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., laws affecting sources of Medicaid funding), the State must submit its methodology to CMS for complying with the change in law. If the methodology were consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in the State, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.

11. **Amending the Demonstration.** The State may submit for CMS consideration a request for an amendment to the demonstration to request exemption from changes in law occurring after the demonstration award date. The cost to the Federal Government of such an amendment must be offset to ensure that total projected expenditures under a modified demonstration do not exceed projected expenditures in the absence of the demonstration (assuming full compliance with the change in law).

IV. ASSURANCES

Acceptance of the Special Terms and Conditions of Approval constitutes the State's assurance that the following will be met:

12. Voluntary Program. The program is voluntary for all current demonstration participants.

13. Fiscal/Employer Agent. A Fiscal/Employer Agent will be available to all participants that choose or need one based on a skills test.

14. Evaluation. The State will conduct an evaluation of the program and will cooperate with an independent evaluation contractor CMS may procure.

15. Reporting of "New" to "Continuing". The ratio of "new" to "continuing" Medicaid personal care services or home and community-based waiver services clients who enroll in (i.e., join) the demonstration in the State of Arkansas may not exceed .41.

16. Public Notice Requirements. The State will comply with public notice requirements as published in the Federal Register, Vol. 59, No. 186, dated September 29, 1994, (Document number 94 -23960) and Centers for Medicare and Medicaid Services (CMS) requirements regarding Native American Tribe consultation.

17. Preparation and Approval of Operational Protocol. The State will prepare an Operational Protocol Document, which represents all policies and operating procedures applicable to this demonstration, and will submit the Operational Protocol to CMS for approval prior to implementation. The State acknowledges that CMS reserves the right not to approve an Operational Protocol in the event that it does not comply with the Special Terms and Conditions of Approval. *Requirements and required contents of the Operational Protocol are outlined in* Section V *of these Special Terms and Conditions.*

18. Adequacy of Infrastructure. This demonstration will provide adequate resources to support participants in directing their own care. The support assures, but is not limited to, participant's compliance with laws pertaining to employer responsibilities, provision for back-up attendants as needs arise, and the performance of background checks on employees and guidance to participants on the results of checks. Adequate resources for implementation, monitoring activities, and compliance to the terms and conditions of approval of the demonstration will be provided by the State.

19. Assistance of a Proxy. This demonstration is designed to assist individuals who are capable of directing their own care. Individuals not capable of directing their own care will not be deliberately excluded from participating in the demonstration. Specifically, persons who require the assistance of others for care planning, or for whom authorization for care must be obtained from a proxy (e.g., a parent or legal guardian/representative) will not be excluded from program participation.

20. Supplant Services. Cash payments provided under this demonstration program do not supplant informal care services that have routinely and previously been available to project participants. Such ongoing informal care services will be identified as a part of each participant's care plan.

21. Contract Approval. The Fiscal Intermediary (FI) contract(s) will be reviewed and approved by CMS prior to the State's requesting Federal financial payments for expenditures incurred under the contract(s).

V. OPERATIONAL PROTOCOL

22. Operational Protocol Timelines and Requirements. The Operational Protocol will be submitted to CMS no later than 90 days prior to program implementation. The CMS will respond within 60 days of receipt of the protocol regarding any issues or areas for which clarification is needed in order to fulfill the terms and conditions of approval, those issues being necessary to approve the Operational Protocol.

The FFP is not available for Medical Assistance Payments prior to CMS approval of the Operational Protocol. The FFP is available for post-approval project development and implementation, and compliance with Special Terms and Conditions.

Subsequent changes to the demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures, including changes to cost-sharing amounts or subsidy amounts, including adjustments for inflation, must be submitted for review by CMS. The State must submit a request to CMS for these changes no later than 90 days prior to the date of implementation of the change(s).

23. Required Contents of Operational Protocol:

a. Organization and Structural Administration. A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform.

b. Reporting Items. A description of the content and frequency of each of the reporting items as listed in Section II and Attachments A and C of this document.

c. Benefits. Descriptions or listings of:

- procedures for determining the plan of care;
- methodology for establishing the budget for the plan of care;
- how purchasing plans are developed;
- procedures and mechanisms to be used to review and adjust payments for the plan of care;
- services which will be cashed out; and,
- Alternative Health Related Services which may be approved for participants, as well as procedures for amending the list of services.

d. Outreach/Marketing/Education. A description of the State's outreach, marketing, education, and staff training strategy. NOTE: *All marketing materials must be reviewed and approved by CMS prior to use.* Include in the description:

- information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers);
- types of media to be used;
- specific geographical areas to be targeted;
- locations where such information will be disseminated;
- staff training schedules, schedules for State forums or seminars to educate the public; and,
- the availability of bilingual materials/interpretation services and services for individuals with special needs. Include a description of how eligibles will be informed of cost sharing responsibilities.

e. Eligibility/Enrollment. A description of the population of individuals eligible for the demonstration (and eligibility exclusions) and population phase-in and the following:

- eligibility determination;
- annual redetermination;
- intake, enrollment, and disenrollment;
- procedures for determining the existence and scope of a demonstration applicant's existing third party liability;
- the State agency that will be responsible for each of the above processes; and,
- a comparison of the number of new individuals accessing Medicaid-funded community based services to the numbers of individuals accessing Medicaid-funded community-based services without the demonstration.

f. Enrollment Ceiling. Description of the enrollment ceiling. This description shall include the process for amending the enrollment ceiling.

g. Quality. Description of an overall quality assurance monitoring plan that includes, but not be limited to the following:

- quality indicators to be employed to monitor service delivery under the demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program;
- the mechanisms the State will utilize to assure that the care needs of vulnerable populations participating in this demonstration (i.e., the elderly and disabled) are satisfied, and that funds provided to these beneficiaries are used appropriately;
- the system the State will operate by which it receives, reviews and acts upon critical events or incidents, with a description of the critical events or incidents;
- case management staff for purposes of monitoring participant health and welfare;
- quality monitoring surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys;

- plans to report survey results, service utilization, and general quality assurance findings to CMS as part of the quarterly and annual reports;
- procedures for assuring quality of care and participant safeguards; and,
- procedures for insuring against duplication of payment between the demonstration, fee for service and Home and Community-Based Services programs; and fraud control provisions and monitoring.

h. Education, Counseling, Fiscal/Employer Agent and Support Services. Descriptions of the following topics will be included:

- the State's relationships and arrangements with organizations providing enrollment/assessment, counseling, training, and fiscal/employer agent services;
- the procurement mechanism, standards, scope of work and payment process for the fiscal/employer agent;
- procedures for ensuring sufficient availability of fiscal/employer agent services for participants who do not pass the mandatory test on employer responsibilities;
- procedures for mandatory testing of participants related to fiscal and legal responsibilities and training opportunities and support services available for participants of the demonstration who require assistance with their fiscal and legal responsibilities; and,
- the procedures for conducting participants background checks on potential providers and informing participants of the results of the criminal background checks.

i. Participant Protections: A description of the State procedures and processes to assure that protections are in place. The description will include the following:

- procedures to assure that families have the requisite information and/or tools to direct and manage their care, including but not limited to employer agent services such as training in managing the caregivers, assistance in locating caregivers, as well as completing and submitting paperwork associated with billing, payment and taxation;
- a viable system in place for assuring emergency back up and emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place;
- procedures for how the State will work with families who expend their individualized budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the continuation of the health and welfare of the individual are available;
- procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination; and,
- process by which the State makes available to participants, at no cost, provider qualification/background checks.

j. Evaluation Design. A description of the State's evaluation design. The description will include the following:

- discussion of the demonstration hypotheses that will be tested;
- outcome measures that will be included to evaluate the impact of the demonstration;
- what data will be utilized;
- methods of data collection;
- effects of the demonstration will be isolated from those other initiatives occurring in the State;
- any other information pertinent to the State's evaluative or formative research via the demonstration operations; and,
- plans to include interim evaluation findings in the quarterly and annual progress reports (primary emphasis on reports of services being purchased and participant satisfaction.)

k. Evaluating, Measuring, and Reporting New to Continuing Client Ratio. The ratio of "new"-to-"continuing" Medicaid personal care services or home and community-based waiver services clients who enroll in (i.e., join) the demonstration in the State of Arkansas may not exceed .41.

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program and those provided under IndependentChoices: Arkansas Cash and Counseling Demonstration under Section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits as specified in Attachment B (Monitoring Budget Neutrality for the demonstration).

2. **a.** In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.c.

b. For each demonstration year, a Form CMS-64.9 WAIVER and/or 64.9P WAIVER will be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.c.).

c. For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of demonstration participants. The services subject to budget neutrality include the following categories as they appear on the CMS-64.9 WAIVER and/or CMS-64.9P Waiver- forms: Home Health Services; Home and Community-Based Services, Personal Care Services; Targeted Case Management; Hospice Benefits; and Other Care Services (such as the subsets of Non-Emergency Transportation and Durable Medical Equipment).

d. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration. Procedures regarding the tracking and reporting of administrative costs will be described in the Operational Protocol to be submitted by the State to CMS under terms specified in Section V.

e. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 Demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

f. The procedures related to this reporting process, report content, and frequency must be discussed by the State in the Operational Protocol (see Section V.)

3. For the purpose of calculating the budget neutrality expenditure cap described in Attachment B, the State must provide to CMS on a quarterly basis the actual number of member/months for the demonstration participant. This information should be provided to CMS in conjunction with the quarterly progress report referred to in number 10 of Section III. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol (see Section V.).

4. The standard Medicaid funding process will be used during the demonstration. Arkansas must continue to estimate total matchable Medicaid expenditures for the entire program on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable/federal share) subject to the budget neutrality cap must be separately reported by quarter for each federal fiscal year on the Form CMS-37.12 for both MAP and ADM. As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2 c. of this Attachment. The CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 annually with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

5. The CMS will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for the following, subject to the limits described in Attachment B:

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.

c. Net medical assistance expenditures made under Section 1115 Demonstration authority, including those made in conjunction with the demonstration.

6. The State will certify State/local monies used as matching funds for the *IndependentChoices* program and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

ATTACHMENT B

MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. This limit will be determined using a per capita cost method. In this way, the State will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an overall expenditure limit for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 3-year extension period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

Projecting Service Expenditures

Each demonstration year budget estimate of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost (MPPC) times the actual number of member months as reported to CMS by the State under the guidelines set forth in Attachment A number 3. The MPPC for DY 1999, 2000 & 2001, is the actual cost experience of the control group and is used instead of the trended cost. The trended costs by DY are the following:

Demonstration Year	Trended Monthly Per Person Cost
DY 2002	$ 801.00
DY 2003	$ 841.00
DY 2004	$ 883.00
DY 2005	$ 927.00
DY 2006	$ 973.00

Impermissible DSH, Taxes or Donations

The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda or regulations. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

Revising the Trended Monthly Per Person Cost

In demonstration programs where participation is voluntary and the participation rate represents a minority percentage of the population eligible to participate, a revision to the trended monthly per person cost in specified demonstration year(s) may be considered by the State and CMS when the state implements provider fee increases that: 1) are irregular in nature; 2) materially exceed the agreed upon trend rate in the year the fee is implemented; and, 3) are implemented through the State Plan and affect the cost of those services included in the demonstration budget neutrality cap on a statewide basis.

The intent of this provision is to protect the state from statewide fee increases that are: 1) pending at time of award but could not be reasonably assessed prior to award or undefined at the time of award; 2) are not included in the historical state experience used in determining the agreed upon budget neutrality cap; and, 3) are not specifically targeted to the demonstration population.

The State, when requesting revision to the MPPC, must provide the following information to CMS on: 1) the full budget effect of the fee increase, including the amount and implementation dates of the current and past fee increases for all services in the MPPC; 2) the MPPC disaggregated by major service categories and number of services for each category, demonstrating the affect with and without the new rate increase; and, 3) the current assessment and projections of with and without waiver costs.

How the Limit will be Applied

The limit calculated above will apply to actual expenditures for long-term care services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the approved extension period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review

The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget estimate plus	8 percent
Year 2	Years 1 and 2 combined budget estimate plus	3 percent
Year 3	Years 1 through 3 combined budget estimate plus	1 percent
Year 4	Years 1 through 4 combined budget estimate plus	0.5 percent
Extended Years		
Year 5	Years 1 through 5 combined budget estimate plus	0.5 percent
Year 6	Years 1 through 6 combined budget estimate plus	0.5 percent
Year 7	Years 1 through 7 combined budget estimate plus	0.5 percent
Year 8	Years 1 through 8 combined budget estimate plus	0.0 percent

ATTACHMENT C

SUMMARY SCHEDULE OF REPORTING ITEMS

Item	Timeframe for Item	Frequency of Item
Monthly Conference Calls	Prior to demonstration implementation and Post-implementation.	Monthly progress calls with CMS and the State.
Operational Protocol	Due to CMS 90 days prior to implementation, CMS comments 30 days prior to implementation, and State completion/CMS approval prior to implementation.	One Operational Protocol. Changes to the Operational Protocol must be submitted and approved by CMS.
Quarterly/Annual Progress Reports	Due to CMS 60 days after the end of a quarter.	One quarterly report per Federal Fiscal Year quarter during operation of the demonstration; the report for the fourth quarter of each year will serve as the annual progress report.
Final Report	Due to CMS 180 days after the end of the demonstration.	One final report.